Enclosure

UPDATE OF CONGRESSIONAL REQUEST FOR VA'S MOST SERIOUS MANAGEMENT PROBLEMS

1. Health Care Quality Management (QM) and Patient Safety

The VA continues to have many challenges to manage, but surely one of the most serious, and potentially volatile, is the need to maintain a highly effective health care QM program. The issues that punctuate the importance of this challenge are VA's need to properly ensure high quality of veterans' health care and patient safety, and to convince Department overseers that VA health care programs are effective. One example of a particularly difficult and complex undertaking in this area is the need to ensure the provision of high quality, safe patient care in an environment that is rapidly evolving to the ambulatory care/outpatient primary care setting from the traditional specialty-based inpatient care. The more rapid pace of ambulatory care presents increased opportunities for clinicians to make errors in treating patients, and the healthcare industry, including the Veterans Health Administration (VHA) has not yet devised effective ways to quickly or accurately identify and correct such treatment errors. Thus, while patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety.

One of the principal issues that bears heavily on the aforementioned problem, that continues to present a management challenge to the Department, is VHA management's inability to provide strong and consistent clinical quality management leadership at all levels of the organization. The devolution of management authority to the Veterans Integrated Service Networks (VISNs) and individual VA medical centers (VAMCs), coupled with resource reductions associated with the Veterans Equitable Resource Allocation model, have led to greatly reduced numbers of clinical managers who are available to identify, evaluate, and facilitate the correction or elimination of clinical quality and patient safety issues. To complicate this problem, VHA managers have not devised any coherent functional descriptions, and have not prescribed any consistent staffing patterns for medical center quality management departments throughout the country. Thus, no two VAMCs' quality management departments focus on the same issues in the same way. These functional and resource disparities severely impede the Department's ability to identify, or measure the extent of possibly widespread unsatisfactory clinical care practices, or to devise procedures to correct or eliminate such problems.

A fully functional QM program should be able to monitor patients' care to ensure their safety, and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events. This risk management function is intended to assure patients that they will be cared for in a manner that promotes their maximum safety while providing them with optimal medical treatment. VHA's managers are vigorously addressing the Department's risk management and patient safety procedures in an effort to strengthen patients' confidence while they are under VA care. Nevertheless, patients continue to be injured in the course of their treatment. In particular, mentally or cognitively impaired patients continue to disappear from VAMCs, and several of these patients have died before searchers could locate them. Six VISNs have various patient safety initiatives focused on this issue, but the magnitude, causes, and possible resolution of the patient elopement problem does not appear to be imminent.

Current Status

We are continuing our follow-up with VHA on our 1998 and 1999 reports that pertain to QM initiatives, and the deployment of QM resources throughout the VHA. We provide the House and Senate Committees on Veterans' Affairs with quarterly reports on VHA's progress to implement recommendations that we made in these reports. We plan to issue a report before the end of the year on our evaluation of VHA's policies and procedures for managing disappearing patients and associated search procedures, as requested by the House Committee on Veterans' Affairs. We also plan to issue a report on our evaluation of certain aspects of patient care quality and safety issues in VHA's Community Based Outpatient Clinic program. Several stakeholders have raised concerns about Community Based Outpatient Clinic effectiveness in ensuring the delivery of high quality, safe patient care, and the Office of Inspector General (OIG) has identified exemplars of related problems in the course of several hotline inspections.

Reports Issued:

Inspection of the Management of a Missing Patient, VAMC Butler, PA, Report No. 9HI-A28-167, Date 9/21/99

Inspection of Two Alleged Serious Patient Falls, Central Alabama Veterans Health Care System, Report No. 9HI-A28-140, Date 7/30/99

Inspection of Alleged Substandard Patient Care and Administrative Discrepancies, Chattanooga Outpatient Clinic, Chattanooga, TN, Report No. 9HI-A28-141, Date 7/30/99

Inspection of Alleged Ventnor, New Jersey Outpatient Clinic Deficiencies, VA Medical and Regional Office Center Wilmington, Delaware, Report No. 9HI-A28-130, Date 6/30/99

Preliminary Assessment of VHA's Missing Patient Search Procedures, Report No. 9HI-A28-084, Date 4/8/99

Oversight Evaluation of VHA's Implementation of its Patient Safety Improvement Policy in Two Sentinel Events, Report No. 9HI-A28-051, Date 3/2/99

Evaluation of Quality Management Staffing and Resources in VHA, Report No. 9HI-A28-042, Date 2/18/99

Inspection of Patient Quality of Care Allegations, and Quality Program Assistance Review, VAMC Togus Maine, Report No. 9HI-A28-039, Date 2/17/99

Inspection of Search Procedures for an Allegedly Missing Patient, VA Central Alabama Health Care System, Report No. 9HI-A28-025, Date 1/11/99

2. **Resource Allocation**

Resource allocation continues to be a major public policy issue. VHA management is addressing staffing and other resource allocation disparities as part of various initiatives to restructure the VA healthcare system. Some of the most significant initiatives include:

Resource Allocation Model. VHA hopes to correct resource and infrastructure imbalances by changing the method used to fund VAMCs. This methodology, called the Veterans Equitable Resource Allocation model, was phased-in during Fiscal Years (FYs) 1997-99. This model allocates funding based on workload (patients treated), rather than incremental increases to prior

year allocations. Such allocations have resulted in reduced funding to some VAMCs that have seen significant reductions in workload, but have continued to receive funding proportionate to prior years workload levels.

Improved Management Information/Performance Measurement. In FY 1998, VHA began implementation of a new cost-based data system that should provide more useful performance measurement information on resources (inputs) and the workload produced (outputs) for clinical and administrative production units. Development of performance measures for clinical and administrative activities will help managers evaluate their clinical productivity and efficiency.

Staffing Reductions and Adjustments. VHA has given VISN directors new authority to reduce physician levels through layoffs in overstaffed specialties. Some networks have begun reducing and shifting staffing as part of consolidations, attrition, and reductions-in-force. VHA is also reducing and reallocating 1,000 resident training positions.

We will continue to monitor VHA's progress in improving the balance in the distribution of staffing and other resources.

Current Status

Our review of the Decision Support System (DSS) standardization found that the potential usefulness of DSS and its data were compromised because some medical center staff had diverged from the system's basic structural standard. Where detected, such divergence had prevented the medical centers' data from being accurately aggregated along with data from other facilities that did adhere to the standard. Also, we were concerned that data divergences that had not been detected may have resulted in inaccurate data being aggregated into roll-up reports. Facilities that had diverged from the DSS structural standard also lost the opportunity to perform a variety of analyses that adhering to the structural standard provides.

Except for the ongoing implementation of the Veterans Equitable Resource Allocation model and the phased reduction and the ongoing reallocation of 1,000 resident training positions that were reported last year, VHA has not provided specific information on actual accomplishments in reducing staffing disparities or in developing performance indicators to evaluate staffing-workload levels at the facility and production unit level. VHA's installation of the DSS was intended to provide the types of management information that would have met the intent of the audit recommendations. However, DSS has not been effectively implemented.

Reports Issued[1]

Audit of VHA Decision Support System Standardization, Report No. 9R4-A19-075, 3/31/99

Audit of VHA Medical Care Usage Patterns and Availability of Resources, Report No. 8R4-A01-048, Date 12/31/97

VAMC Administrative Staffing Levels, Report No. 6R8-A99-055, Date 5/28/96

VHA Resource Allocation Issues: Physician Staffing Levels, Report No. 5R8-A19-113, Date 9/29/95

[1] Most reports issued after October 1, 1997 are available on our Web Site: http://www.va.gov/oig/53/rrp700/monthly.htm

3. Claims Processing, Appeals Processing, and Timeliness and Quality of Compensation and Pension (C&P) Medical Examinations

Veterans Benefits Administration (VBA) needs to improve the timeliness of claims processing. Numerous studies, reviews, and audits have addressed timeliness and quality issues with VBA's C&P claims processing system. The system is used for the overall administration of almost $22 billion in compensation and pension payments to veterans annually.

Claims Processing

VBA has reduced pending benefit claims, but the backlog remains significant, totaling 435,299 claims in FY 1999 from a peak of 474,000 claims in FY 1994. Processing of original compensation claims reached an average high of 213 days in FY 1994, and required an average 205 days in FY 1999.

VBA has sought to address claims processing timeliness through improved training, organizational changes, and modernization efforts. The Department has completed two major reviews to devise ways to improve claims processing and attempted to initiate restructuring of its field operations in 1996. This effort was rebuffed by Veterans Service Organizations, which were concerned that geographic reorganizations and consolidations would reduce their effectiveness in representing veterans.

Current Status

Timeliness of compensation and pension claims processing continues to be a major problem. In FY 1998, VA fell short of achieving its claims processing timeliness goals. The Department is taking action to improve the accuracy of reported timeliness of claims processing. An OIG audit found that actual timeliness was well above reported timeliness. The Under Secretary for Benefits is taking aggressive action to assure that performance data covering benefits programs are accurately reported by all VA regional offices (VAROs).

Our 1997 review "Summary Report on VA Claims Processing Issues" identified opportunities for improvement in the timeliness and quality of claims processing and in veterans overall satisfaction with VA claims services. Unfortunately, VBA has not been able to take advantage of all of these opportunities because of the long implementation schedule that it has projected for completing key improvements in processing claims. The report recommendations relating to implementation of the Veterans Service Network program and VARO restructuring are not expected to be achieved until after FY 2000. VBA is currently implementing its Business Processing Reengineering rules and pension simplification team report that was highlighted in our audit report. The audit highlighted 18 regulatory changes considered necessary for full implementation of the Business Processing Reengineering. In response to the report recommendation, VBA has also developed an automated checklist to document evidence requests concerning each claim. The automated checklist is being used in the Business Processing Reengineering case management pilots at six VAROs. National implementation is expected in FY 2000.

Report Issued

Summary Report on VA Claims Processing Issues, Report No. 8D2-B01-001, Date 12/9/97

Appeals Processing

Veterans have historically had to wait a long time to receive a decision on appeals of benefit claims. Large claims backlogs have continued to impact the Department's ability to provide veterans with timely service, in some cases veterans have had to wait years for decisions on their claims.

While the Department has made progress in reducing case processing times, there is concern about the quality of decision making at VA regional offices. During FY 1999, the Board of Veterans' Appeals completed 37,373 appeal decisions.

The 1988 Judicial Review Act established the U.S. Court for Veterans Claims and expanded VA due process requirements, which increased appeals processing time.

Current Status

No Change

Report Issued

Appeals Processing Impact on Claims for Veterans Benefits, Report No. 5D2-B01-013, Date 3/15/95

Timeliness and Quality of C&P Medical Examinations

Disability benefit payments are based, in part, on interpretations of medical evidence by VBA disability rating specialists. That evidence is developed by VHA physicians, VHA supervised physicians, or private contractors through the examination of the veteran claimant. Proper medical examination services are important because VBA cannot complete payment on veterans' disability claims until examination results are received. When a medical examination is not performed correctly the veteran must have another examination scheduled, which can result in significant claim processing delays.

Our 1997 report "Review of C&P Medical Examination Services" followed up on our 1994 recommendations to improve the timeliness of C&P examination services. We found that management had made efforts to improve examination services, but little improvement had been made. We recommended that the Undersecretaries for Benefits and Health improve the quality and timeliness of C&P examinations by establishing performance measures for their field facilities, with the objective of reducing the number of incomplete examinations; by requiring VBA area directors and VHA VISN directors to monitor progress in reducing the percentage of incomplete examinations; and by requiring VBA and VHA directors to work together to reduce the percentage of incomplete examinations.

Current Status

VHA implemented their recommendations. VBA implement two recommendations, but they had not completed implementation of the recommendation to establish performance measures for their field facilities, with the objective of reducing the number of incomplete examinations. VBA is collecting additional data in conjunction with the contract disability examination pilot project and development of an action plan under the joint disability examination steering committee.

Reports Issued

Review of C&P Medical Examination Services, Report No. 7R1-A02-114, Date 8/6/97

Timeliness of C&P Medical Examination Services, Report No. 4R1-A02-092, Date 7/11/94

4. Inappropriate Benefit Payments

VBA needs to develop and implement a more effective method to identify inappropriate benefit payments. Recent OIG audits found that the appropriateness of C&P payments has not been adequately addressed.

Dual Compensation of VA Beneficiaries

A review of VBA procedures in place to ensure that the disability compensation benefits of active military reservists were properly offset from their training and drill pay, found that procedures to prevent dual compensation need to be improved. We found that 90 percent of the potential dual compensation cases reviewed had not had their VA disability compensation offset from their military reserve pay. We estimated that dual compensation payments of $21 million were made between FYs 1993 and 1995. Further, if this condition was not corrected, estimated annual dual compensation payments of $8 million would continue. Dual compensation payments have occurred since at least FY 1993 because procedures established between VA and the Department of Defense (DoD) were not effective, or were not fully implemented

Current Status

Our recommendations that VBA (i) negotiate a matching agreement with DoD that includes provisions for VBA to solicit waivers from beneficiaries who have not submitted waivers and a formal mechanism for informing DoD of beneficiaries requiring reservist pay offset, (ii) followup on Fiscal Years 1993 through 1996 dual compensation cases to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservist pay, and (iii) work with DoD and veterans service organizations to improve communications with beneficiaries regarding their responsibilities to prevent dual compensation, remain unimplemented.

Report Issued

VBA's Procedures to Prevent Dual Compensation, Report No. 7R1-B01-089, Date 5/15/97

Payment to Incarcerated Veterans

Our review of benefit payments to incarcerated veterans found that VBA officials did not implement a systematic approach to identify incarcerated veterans and dependents, and adjust their benefits as required by Public Law 96-385. A prior audit conducted in 1986 found that controls were not in place to cut off benefits to veterans when they were incarcerated. In that audit, we recommended that a systematic approach be applied, but actions were not taken to implement the recommendations in the 1986 report.

According to the Department of Justice, Bureau of Justice Statistics, the Federal and State prison populations more than doubled since 1986, from 522,100 to 1,085,400. In addition, about 4.6 million individuals have been admitted to, and about 4.1 million inmates have been released from, Federal and State prisons since 1986.

The current evaluation included review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustment, resulting in overpayments totaling $1.8 million. Projecting the sample results nationwide, we estimate that about 13,700 incarcerated veterans have been, or will be, overpaid about $100 million. Additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents, if VBA does not establish a systematic method to identify these prisoners.

Current Status

Our recommendation that VBA enter into a matching agreement with the Social Security Administration (SSA) for prison records was recently implemented. However, our recommendations that VBA (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure VAROs process identified cases timely and properly adjust benefits, are all unimplemented.

Reports Issued

Evaluation of Benefit Payments to Incarcerated Veterans, Report No. 9R3-B01-031, Date 2/5/99

Benefit Payments to Incarcerated Veterans, Report No. 6R3-B01-110, Date 7/16/86

Payment to Deceased Beneficiaries

A February 1998 audit of VBA's current procedures to terminate beneficiary C&P benefits based on information about veterans' deaths received from SSA, found that VBA needs to develop and implement a more effective method to identify deceased beneficiaries and to timely terminate their C&P benefits. Based on information about veterans' deaths received from SSA, audit results showed that, only 156 of a sample of 281 veterans reported by SSA as deceased were, in fact, deceased. C&P benefit awards for 42 of 156 deceased claimants were (i) still running; (ii) had incorrect termination dates; or (iii) had incorrect suspense dates. Overpayments in these 42 cases totaled $340,000. We estimated approximately $3.9 million in erroneous payments were made throughout VBA.

Current Status

VA reports that VBA's Master Veteran Record project is providing Notice of Death transactions to VA components by sending C&P extracts to the Master Veteran Record National Data Broker. Also, VBA has allocated the funds necessary to accomplish additional improvements.

Report Issued

Audit of VBA Social Security Administration/VA Death Match Procedures, Report No. 8R4-B01-069, Date 2/6/98

5. Government Performance and Results Act (GPRA) - Data Validity

GPRA requires federal agencies to set goals, measure performance against those goals, and report on their accomplishments. In accordance with the law, VA has set goals for each of its

major business lines, identified related performance measures, and established procedures for compiling and reporting results.

Prior OIG audits have found erroneous data in many VA financial and management systems – medical care ($18.4 billion annually), compensation ($18.8 billion annually), pension ($3.1 billion annually), and education ($1.4 billion annually). Inaccurate data in VA records results in faulty budget and management decisions, and adversely impacts program administration.

At the request of the Assistant Secretary for Planning and Analysis, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. We have completed audits of five performance measures[2]:

- Average days to complete original disability compensation claims.
- Average days to complete original disability pension claims.
- Average days to complete reopened compensation claims.
- Percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence.
- Unique patients.

We identified deficiencies in each of the measures, and VBA and VHA are taking action to correct the deficiencies.

VA has made progress in implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and Department-wide weaknesses in information system security limit our confidence in the quality of data output.

Current Status

Audits of three performance measures -- the foreclosure avoidance through servicing ratio, the prevention index, and the chronic disease care index -- are in process.

Reports Issued:

Accuracy of Data Used to Count the Number of Unique Patients, Report No. 9R5-A19-161, Date 9/20/99

Accuracy of Data Used to Measure Percent of Veterans with a VA Burial Option, Report No. 9R5-B04-103, Date 5/12/99

Accuracy of Data Used to Measure Claims Processing Timeliness, Report No. 9R5-B01-005, Date 10/15/98

Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act, Report No. 8R5-B01-147, Date 9/22/98

[2] The three claims processing timeliness measures we audited have now been incorporated into a new key measure called average days to process rating-related actions.

6. **Security of Systems and Data**

VA needs to improve physical and electronic security over its information technology (IT) resources. The Department requires automated data processing (ADP) of transactions valued at over $28 billion annually, and maintenance of over 40 million sensitive veteran records. Security risk increases as data is shared among VA departments and organizations. Multiple architectures and complex mission-specific systems throughout VA increase the risk of inappropriate access and misuse of sensitive data.

Historically, sufficient security has not been provided VA IT resources. For example:

- Comprehensive security programs were not in place at data centers.
- Risk assessments were not developed and maintained.
- Center-wide security plans had not been developed.
- Systems were not certified.
- Numerous physical and electronic security controls needed to be implemented.

Current Status

Ongoing assessment of ADP controls are taking place. We are continuing our assessment of ADP controls and corrective action in-process as part of our audit of VA's FY 1999 Consolidated Financial Statements, which is still in progress. To address the VA-wide ADP security and control issues, VA established a centrally managed security group in FY 1999 and an information security working group, in which we participate. The actions necessary to reduce risk to an acceptable level require a long-term, sustained effort. VA's security workgroup developed 11 initiatives, known as the Information Security program. Implementation of these initiatives is estimated to cost $83 million over 5 years. In 1999, VA redirected $1.8 million for the program and plans to redirect remaining FY 2000 money from the Year 2000 project. The FY 2001 budget request includes $17.5 million for the program.

In our audit of VA's FY 1998 Consolidated Financial Statements, we reported VA-wide information system security controls as a material internal control weakness. The General Accounting Office (GAO) reached similar conclusions and noted various corrective actions initiated.

Reports Issued

VA's Consolidated Financial Statements for FY 1998, Report No. 9AF-G10-061, Date 3/10/99

GAO Information Systems - The Status of Computer Security at the Department of Veterans Affairs, Report No. GAO/AIMD-00-5, Date October 1999

VA's Consolidated Financial Statements for FYs 1997 and 1996, Report No. 8AF-G10-103, Date 5/18/1998

Security Controls for the Integrated Data Communications Utility, Report No. 8D2-G07-066, Date 4/23/98

Security Controls at the Hines Benefits Delivery Center, Report No. 7D2-G07-062, Date 5/13/97

VHA's Security for the Decentralized Hospital Computer Program, Report No. 6R5-A99-085, Date 9/20/96

Security Controls at VA Automation Center, Austin TX, Report No. 6D2-G07-060, Date 7/12/96

7. VA Consolidated Financial Statements

Some VA assets may not be adequately protected and resources may not be properly controlled; further improvements are needed to carry out stewardship responsibility for VA assets and resources.

Based on our audit report of VA's FY 1998 Consolidated Financial Statements, we qualified our audit opinion concerning Housing Credit Assistance program balances. The section of the report on Internal Control Structure discusses two materiel weaknesses concerning VA-wide information system security controls, and Housing Credit Assistance program accounting and financial reporting. We reported a third internal control issue, involving accounting for medical facility receivables, as a reportable condition. The section of the report on Compliance with Laws and Regulations discusses three areas of noncompliance. Two items dealt with the Department not complying with Federal Financial Management Improvement Act requirements concerning (i) Housing Credit Assistance program accounting and financial management information systems and (ii) VA-wide information system security requirements. The third concerned noncompliance with two other laws concerning requirements for charging interest and administrative costs on C&P accounts receivable, and requirements for funding minimum staffing levels in the VA OIG, while not material to the financial statements, warrant disclosure.

Current Status

Audit of VA's FY 1999 Consolidated Financial Statements is in process and includes assessment of completed and in-process corrective actions by the Department.

Report Issued:

VA's Consolidated Financial Statements for FY 1998, Report No. 9AF-G10-061, Date 3/10/99

8. Debt Management

As of September 1999, debt owed to VA totaled over $4.3 billion. This debt resulted from home loan guaranties, direct home loans, life insurance loans, medical care cost fund receivables, compensation and pension overpayments, and educational benefits overpayments.

Current Status

Over the past 18 months, audit coverage of VA's debt management program has focused on billing and collection of medical care copayments owed by veterans or their insurance companies for medical care of non-service connected conditions, and overpayments of compensation and pension benefits.

The OIG has issued 15 reports over the last 4 years, addressing the Department's debt management activities. The recurring themes are that the Department should be more aggressive in collecting debts, improve debt avoidance practices, and streamline and enhance credit management and debt establishment procedures. Through improved collection practices, the Department can increase receipts from delinquent debt by tens of millions of dollars each year.

Following, are determinations made on some of the 15 reviews. Our review of debt prevention, debt consolidation, and debt collection issues identified opportunities to avoid overpayment, establish debt, or improve collection of $260 million:

- $30.5 million in debts that need to be established,
- prevention of new debts caused by benefit overpayments of about $81.1 million annually,
- need to enhance debt collection by about $129.7 million, and
- need to streamline operations and achieve annual cost efficiencies of about $18.7 million.

In addition to realizing significant monetary benefits, these audits identified opportunities to help enhance service to veterans by identifying benefit underpayments of about $14 million, and preventing the inappropriate billing or income verification of about 14,000 veterans.

We have issued several reports addressing income verification match issues. Our "Evaluation of VHA's Income Verification Match Program" followed up on implementation of recommendations from prior income verification match audits. We reported that prior recommendations had not been fully implemented and that opportunities existed for VHA to conduct the program in a more efficient and cost effective manner. We recommended that the Under Secretary for Health improve the income verification match program activities by: (i) requiring VHA's Chief Network Officer to ensure that VISN directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center referrals, (ii) requiring VHA's Chief Information Officer to develop performance measures and monitor periodic performance reports, and (iii) expediting action to centralize means testing activities at the Health Eligibility Center. Our recommendations had not been implemented.

We have also issued several reports addressing how to improve VHA's Medical Care Cost Recovery program. VHA has reported implementation of all of our report recommendations, however we have not completed follow up work to document the improvements.

We have issued two reports addressing C&P benefit overpayments, that have unimplemented recommendations. The first, "Review of the Causes of VBA's C&P Overpayments," made a series of recommendations to reduce overpayments. One recommendation was to reduce overpayments by revising due process procedures to allow oral, as well as written, beneficiary notifications that will result in a reduction in the beneficiary's benefits. On November 8, 1999, VBA reported that they have been unable to develop the draft change to the pertinent regulations due to staffing changes. All other recommendations have been implemented. The second report, "Evaluation of the Effectiveness of VBA's Controls to Detect and Prevent C&P Benefit Payment Errors," included a recommendation to improve controls to prevent C&P payment errors by eliminating or suppressing C&P system messages that do not impact payment accuracy or customer service. On December 10, 1998, VBA reported that their project to discontinue issuances of such messages had been delayed by other priority ADP projects. All other recommendations had been implemented.

Reports Issued

Evaluation of VHA's Income Verification Match Program Report No. 9R1-G01-054, Date 3/15/99

Audit of VHA Actions on Accounts Receivable, Report No. 8AN-G01-117, Date 8/6/98

Audit of the Medical Cost Recovery Program, Report No. 8R1-G01-118, Date 7/10/98

Evaluation of the Effectiveness of VBA's Controls to Detect and Prevent C&P Benefit Payment Errors, Report No. 8R1-B01-083, Date 3/24/98

Means Testing for Income Verification Procedures, Report No. 7R1-G01-096, Date 6/10/97

Waiver Decisions for C&P Debts, Report No. 7R1-B01-047, Date 2/21/97

Review of the Causes of VBA's C&P Overpayments, Report No. 7R1-B01-105, Date 12/2/96

Effectiveness of Benefit Award Notification, Report No. 6D2-B01-049, Date 9/20/96

VBA's Income Verification Match, Report No. 6R1-G01-027, Date 3/27/96

VHA's Income Verification Match Program, Report No. 6R1-G01-021, Date 3/27/96

Selected Aspects of the Medical Cost Recovery Program, Report No. 5R1-G01-121, Date 9/29/95

VBA Claims Processing Procedures for C&P Benefit Overpayments, Report No. 5R1-B01-106, Date 9/15/95

PCIE – Coordinated Review Federal Credit Management and Debt Collection Issues, Report No. 5D1-G01-087, Date 7/24/95

Impact of Due Process on C&P Benefits Overpayments, Report No. 5R1-B01-037, Date 2/8/95

Pension Reductions for Beneficiaries Receiving Medicaid Sponsored Nursing Home Care, Report No. 5R1-B02-014, Date 12/13/94

Accuracy of C&P Benefits Payments to Hospitalized Veterans, Report No. 4R1-B01-102, Date 8/2/94

9. **Workers Compensation Costs**

The 1916 Federal Employees' Compensation Act (FECA) authorizes benefits for disability or death resulting from an injury sustained in the performance of duty. The U.S. Department of Labor (DOL) administers the FECA program for all Federal agencies. The benefit payments have two components - salary payments and payments for medical treatment for the specific disability. Medical treatment includes all necessary care, including hospitalization. The DOL indicates that payments made to injured Federal workers is about $1.8 billion annually for all Federal agencies, and approximately $140 million annually at VA. These benefit payments are at risk to fraud, waste, and abuse.

We audited VA's FECA program in 1998 and concluded the program was not effectively managed and that by returning current claimants to work who are no longer disabled, VA could reduce future payments by $247 million. (The DOL calculates savings based on the age of the recipient at the time of removal up to age 70, the life expectancy of these individuals.) We also identified 26 potential fraud cases from our random sample, which were referred to our Office of Investigations. Based on the sample results, we estimated there were over 500 fraudulent cases being paid about $9 million annually. Similar conditions were reported in a 1993 OIG report.

Current Status

The OIG developed a protocol package and handbook for enhanced VA oversight and case management of the Workers Compensation Program (WCP). Both documents discussed key elements of case management and fraud detection. The protocol package was customized for individual VISNs and included a list of specific cases for review.

The OIG continues to work with the Department to reduce WCP costs through individual VISN case management reviews, staff training, and aggressive investigation of identified fraudulent cases. Review work has already been completed in VISNs 2, 8, and 22. Work is now being initiated in VISNs 4 and 5. Individual cases of suspected fraud are referred to the Office of Investigations for review. After investigation and successful prosecution, restitution to VA is incorporated into judicial actions taken, thus returning to VA monies fraudulently received.

The Department is also providing WCP staff training and assistance to selected VISNs and held a national WCP conference in 1999 to provide a forum for training and discussion of WCP issues. While the Department has taken a number of positive steps to address WCP issues, implementation of recommendations included in our 1998 audit of VA's WCP cost have not been fully completed. Key actions remaining include:

- One-time review of all open/active cases. (VISNs have been slow to begin case review work. We are continuing to provide training and case management assistance to selected VISNs who have requested assistance.)
- Implementing the system modifications discussed in the report. (Implementation action has been delayed due to budget constraints.)
- Issuing policy and guidance on recording, tracking, and using "continuation of pay" information. (Implementation action cannot be completed until HR LINK$ system platform is completed.)

Implementation of these recommendations is essential for the Department to strengthen its WCP case management and reduce program cost. Given the significance of the audit findings and the continued risk of program abuse and fraud, the WCP continues to be an internal high priority area.

Reports Issued

Protocol Package for VISN Workers' Compensation Program Case Management and Fraud Detection, 9D2-G01-002, Date 4/14/99

Handbook for Facility Workers' Compensation Program Case Management and Fraud Detection, 9D2-G01-064, Date 4/14/99

Audit of VA's Workers' Compensation Program Cost, Report No. 8D2-G01-067, Date 7/1/98

VA Management of Federal Employees Compensation Act Program, Report No. 3R1-A99-174, Date 9/30/93